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INTRODUCTION

Juvenile courts across the country, without exception, are ill-equipped to handle the problems of mentally disordered[1] juveniles in need of professional therapeutic intervention. While the relative number of juveniles needing psychiatric care might be considered small when compared with juvenile offenders as a whole, the magnitude of the problems which this group creates should not be underestimated. It is with the methods and practices used by juvenile courts attempting to handle these problems that this article is mainly concerned.[2]

Before attempting to generalize about the juvenile courts' handling of mentally disordered juveniles, a cautionary note should be struck. Since juvenile court statutes provide comparatively little guidance, the practices and procedures pertaining to the mentally disordered juvenile can and do vary greatly among the states and even among juvenile courts within the same state. Also, since the availability of treatment resources is generally very limited, each case must be dealt with on a highly individualized basis. Formal and rigid legal procedures would probably be unworkable given the current scarcity of treatment possibilities. This assumption, however, does not imply that greater regularity in the handling of mentally disordered juveniles is not necessary.

I. PRE-JUDICIAL HANDLING OF THE MENTALLY DISORDERED JUVENILE

By far the greatest number of juvenile delinquency complaints never reach the adjudicative stages of the juvenile court process.

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1. The term, *mental disorder,* as used in this article encompasses the term in the broadest sense. It is not limited to define those who might be categorized as being mentally ill, psychotic or legally insane.

2. A Questionnaire Survey [hereinafter cited as Survey] dealing with mentally disordered juveniles was conducted by this writer under the auspices of "The Judicial Conference Project on Laws Pertaining to Mental Disorders, Judicial Conference for the Circuit of the District of Columbia." Of approximately 100 judges contacted, 35 replied. Since the questions focused upon court treatment of mentally disordered juveniles, much of the results and information obtained in the Survey will be included in this article.

These cases are either dropped or diverted to supportive resources in the community by police, prosecutors and court social workers in the pre-judicial stages of the juvenile's contact with the court. While statistics are not available, there are clearly many juveniles with mental disorders among those whose complaints are disposed of in the early stages. In addition, in some cases the juvenile's mental condition may be the primary reason for the decision not to refer or to formally petition the complaint to the juvenile court.

A. Police

Police officers and juvenile officers are seldom given specific directions on how to proceed in the case of a juvenile who presents obvious mental problems. Where the police have developed formal procedures for screening out cases which are not to be referred to the juvenile court, the screening process is generally based upon criteria having only to do with the seriousness of the offense and the juvenile's prior arrest record. Even where police have authority to initiate commitments under mental health laws, they appear to be reluctant to exercise this power and prefer to let the juvenile courts handle the matter.

Thus, the police's role in helping to identify mental problems is extremely small. Complaints are usually referred to juvenile court without any personal observations of the arresting officer being noted thereon. In rare instances the police may indicate behavior on the complaint which they believe shows that the juvenile has a mental problem, but generally communication between the court social service staff and police is confined to the facts surrounding the incident complained of.

There is little doubt that greater effort could be made to utilize police experience in the early detection of mental problems. This statement simply means that impressions which police could gather about a particular child's mental condition would be passed on to the court so that the court social service department can act as swiftly as possible when mental problems are detected. In addition, it is probably best that police are not encouraged to engage too deeply in informal adjustments of complaints at the station house because their means of following up to make sure that treatment is being received are far too limited. The proper body to accomplish informal adjustments and referrals is the juvenile court social service department.

B. Representatives for the State

The exact role that the representative for the state should take in the juvenile court process is the subject of great debate and

uncertainty. To date state systems vary widely on the matter of who represents the state's interest in the juvenile court. However, whether the state is to be represented by the police, district attorney, or other official, greater effort must be made to focus their attention on the special problems of the mentally disordered juvenile. As the role of the state's representative increases, as is very likely, greater care will have to be given to the precise role he will play in bringing about such things as administrative probation with psychiatric conditions, civil commitments and like procedures. Presently, the representatives of the state have relied almost exclusively on the social service department's (intake) decisions on whether a case is to be petitioned and what is to be done with the juvenile if it is not petitioned.

C. Intake

Most juvenile court statutes provide for intake procedures.[3] Intake is one of the unique features of the juvenile court system, although various new kinds of early diversion programs being tried out in the adult criminal courts actually come close to it. The main purpose of intake provisions[4] is to compel the court through its social service staff to assess whether or not all of the circumstances of a case, particularly the rehabilitative potential of the accused juvenile, justify the filing of a formal petition.

It is at the intake stage that many juveniles' mental problems are first discovered. Unfortunately, intake procedures are very hurried and never are based upon complete information as is ultimately made available after the formal social investigation has been made for dispositional purposes.[5] In cases of obvious emergency, such as when a child in a catotonic condition is brought into the court, hospitalization may be the social worker's (intake officer's) only recourse for action. In other cases where less serious mental problems are involved, the intake officer really has only three choices: (1) dismiss the complaint,[6] (2) adjust the complaint informally[7] or (3) petition the case. The intake worker can also

3. *See generally* PRESIDENT'S COMM'N ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, TASK FORCE REPORT: JUVENILE DELINQUENCY AND YOUTH CRIME 14-22 (1967) [hereinafter cited as TASK FORCE REPORT].

4. Typically such provisions provide that: "the court shall make a preliminary investigation to determine whether the interests of the public or of the minor require that further action be taken." HAWAII REV. LAWS § 333-12 (1955). *See also, e.g.,* ORE. REV. STAT. § 419. 482(2) 1967); IND. ANN. STAT. § 9-3208 (Supp. 1968).

5. Some people recommend that all juveniles coming before the juvenile court be given psychological tests. There are, however, tremendous practical problems in such a suggestion and the tests would probably be of marginal value given the paucity of treatment resources which exist.

6. Intake officers theoretically do not legally dismiss complaints but their recommendations based upon social factors are generally controlling in the outcome of a particular complaint.

7. Sometimes intake workers simply postpone their decision as to whether or not to

recommend that psychological testing be done, but, unless the juvenile has appeared in court before and already been tested, the intake decision will usually be made without the benefit of psychological reports.

Juvenile courts generally look with favor upon informal adjustments based upon the receipt of some sort of psychiatric care where such care is necessary. There are several reasons for this practice:

(1) Many mental health facilities, both public and private, refuse to accept the mentally disordered juvenile who has a court record. These facilities are reluctant to become involved in legal proceedings. They also maintain that delinquents are too disruptive to their treatment programs. Therefore, the less contact a juvenile has with the court in a formal sense the better are his chances for obtaining treatment.

(2) many correctional facilities and authorities are also reluctant to handle the mentally disordered juvenile delinquent.

(3) parental cooperation is deemed necessary to successful psychiatric treatment programs, and thus, the sooner this cooperation is obtained the sooner the child will get the needed treatment.

(4) there is a pervasive belief, not articulated in statutes or formal procedures, that seriously disturbed juveniles should not go through the formal adjudicative process. While legal competency to stand trial is seldom raised formally, it does appear in cases involving serious mental problems. The courts make every effort to divert the juvenile from the formal adjudicative process into psychiatric facilities.

1. Kinds of Treatment Obtained at the Intake Stages

The kinds of treatment obtained in the pre-judicial stages of the juvenile court process for mentally disordered juveniles do not differ greatly from those ordered at disposition.

a. Outpatient clinic care is the most widely utilized form of treatment since it is usually the most readily available. There are, however, many difficulties involved in obtaining admission to outpatient clinics: (1) most facilities have long waiting lists and employ complicated admission procedures; (2) most outpatient clinics, public and private, employ admission qualifications such as age, sex, and kind and degree of mental disorder; (3) most importantly, admission policies usually require the active cooperation of a parent in the juvenile's treatment program. In most cases, this means that the parent must, at least, initially contact the clinic

petition a complaint, and thereby try to influence the respondent's conduct without taking any official action. It is these arrangements which juvenile statutes are now trying to regulate as to their duration and condition under the heading of "informal adjustments".

for an interview. Failing this, the opportunity for admission to the clinic is denied to the child.[8]

b. When a juvenile is in need of residential care, greater obstacles are presented than in the case of out-patient care. State hospitals are very crowded and many do not provide special treatment for children, although this situation appears to be changing. In most cases a candidate for residential treatment must be *acutely* psychotic to qualify for admission to a state hospital.

Private residential psychiatric facilities are usually beyond the financial reach of juveniles and their families under the jurisdiction of the court. The rigidly maintained entrance qualifications of these facilities are usually aimed at the child who shows a definite potential for becoming a productive citizen in the community. A California juvenile judge states that: "most voluntary admissions are [from] middle and upper class families. It depends on the financial condition of the parents."[9] Since the juvenile in the pre-judicial stages is not under juvenile court jurisdiction or a ward of the court, public funds, available in certain cases to wards of the court are simply nonexistent.

c. In only rare instances do the court clinics administer extensive treatment programs. They are used almost solely for diagnosis and evaluation. The reason for this is largely financial and a matter of inadequate staffing. Some persons believe, however, that treatment within the court context is both inappropriate and unsuitable.

In addition to the inadequacy of psychiatric resources, the attitude of individual parents toward their children's mental problems clearly inhibits voluntary, pre-judicial psychiatric adjustments. Several juvenile court judges state the situation thusly: (1) The parents "refuse to admit or are unable to comprehend the nature of their children's problems."[10] (2) Others "seem to be reticent to have the children blame the parent for the admission,"[11] and "fear the stigma attached to mental illness."[12] (3) Still others "feel that the action or the handicap of the child reflects some failure on their part,"[13] or they "don't understand that commitment is for help not punishment."[14]

It can readily be seen, then, that there are some juveniles with mental problems whose cases might be informally adjusted but for their parents' unwillingness to cooperate or their lack of financial

8. Financial considerations are not usually an obstacle to obtaining outpatient treatment. Ability to pay is usually the cost standard at public and most private clinics.
9. Survey, *supra* note 2.
10. Survey, *supra* note 2.
11. Survey, *supra* note 2.
12. Survey, *supra* note 2.
13. Survey, *supra* note 2.
14. Survey, *supra* note 2.

resources. Court involvement, however, following adjudication probably only increases a juvenile's chances for obtaining treatment in certain state hospitals and for gaining access to funds from public sources which hinge on the juvenile becoming a ward of the court.

2. What Happens to Pending Charges When Informal Adjustments Occur

What happens to pending charges when adjustments based on voluntary psychiatric treatment are made varies among the juvenile courts. Practically no statutory guidance is given to juvenile judges and personnel with respect to the charges when informal adjustments take place. Generally juvenile judges are simply given the authority to dismiss delinquency proceedings at any time in their own discretion. Statutory provisions may provide time limits for informal adjustments but they generally do not provide any guidance on what happens to the original charges.

An Ohio juvenile judge states what would appear to be the usual practice among juvenile courts:

> In most cases any voluntary admission is made before adjudication. If so, no purpose is served by a delinquency hearing. In the case where adjudication has already been made it is not considered proper to vacate the order. [Admission here means residential care.][15]

The fact, however, that nor further hearing takes place does not mean that the pending charges are dropped. A Texas juvenile court judge states that:

> Whether a petition is adjudicated, passed or vacated is usually determined by several factors; seriousness of offense, condition of child, whether treatment has been arranged for and parent and child attitude.[16]

The charges may be kept open to specifically allow the court to carry on certain functions. In certain cases the juvenile court only acts as a coercive influence in the child's treatment program. A Utah juvenile judge states that: "sometimes the residential treatment center, (state hospital), requests that the court keep jurisdiction open so that the child cannot leave before treatment is complete."[17] Other courts actually involve themselves in the treatment program of the mental institution, such as when social workers

15. Survey, *supra* note 2.
16. Survey, *supra* note 2.
17. Survey ,*supra* note 2.

confer regularly with hospital staff. This situation is rare. Most juvenile courts just stay in the background and receive reports and remain ready to provide services if such are requested.

Some facilities may require that the pending charges be dropped by the court before they will accept the child. This procedure is not the usual case, however.

As a general rule, then, juvenile courts will usually keep the delinquency charges open at least until treatment is assured, or until the court's services are no longer needed. In cases where a juvenile is admitted to treatment on an inpatient basis and is a considerable threat to the safety of the community, the court will hold the charges open to protect against a premature release by the hospital authorities or an escape from the institution. In cases where treatment is received and/or where the juvenile does not get in further trouble, the charges while not usually formally dropped, fall into desuetude. Clearly, in cases where the treatment program breaks down and where confinement appears necessary, a hearing on the charges will be ordered with the possibility of commitment to a correctional institution.

3. Psychiatric Care in Detention Facilities

Psychiatric care for the mentally disordered juvenile in detention is practically nonexistent. If a juvenile in detention is seen by a psychiatrist, psychologist, or psychiatric social worker, it is usually for an emergency or diagnostic workup. Many juveniles are placed in detention for the specific purpose of obtaining a mental examination.[18] It is usually only the juvenile who acts out in a manner dangerous to himself or to others who receives attention in the form of a psychiatric intervention or emergency commitment to a mental hospital. The passive juvenile who is nonetheless severely disordered goes unnoticed and uncared-for.

While there are dangers that treatment programs in detention facilities will become substitutes for proper long term care, the very long periods of time that some juveniles are kept make better psychiatric care in these facilities absolutely necessary. The Circuit Court of Appeals for the District of Columbia has recognized this need. The Court has held that the District of Columbia Juvenile Court has a duty to inquire into the question of whether proper treatment is being accorded juveniles in detention "when presented

18. Makover states that:
> Some thirty per cent of appointments made in the BMHS clinic for children are not kept and, therefore, the judge often finds it necessary to detain the child in Youth House to insure his getting the examination.

MAKOVER, MENTAL HEALTH SERVICES IN THE FAMILY COURT OF THE STATE OF NEW YORK IN THE CITY OF NEW YORK 29 (1966) [hereinafter cited as MAKOVER REPORT].

with a substantial complaint."[19] Traditionally the courts have not reviewed matters relating to pre-dispositional care and treatment.

The problem of psychiatric care in detention facilities could be greatly lessened if court cases were speeded up, *fairer* detention practices were adopted, more defense attorneys were available and more residential psychiatric facilities were made available for both examinations and inpatient treatment.

II. INCOMPETENCY TO STAND TRIAL IN JUVENILE COURT

A. Status of the plea of incompetency to stand trial

Mental competency to stand trial has received little attention as a formal legal concept by the juvenile courts and writers in the field.[20] In theory, juvenile courts were set up to handle all of a juvenile's problems, including mental and emotional ones, at disposition. The mental condition of the respondent at the time of the hearing was not relevant to the court's jurisdiction over the child. As a practical matter, however, juvenile judges are concerned with the concept of mental incompetency to stand trial. Judge Ketcham took this position in the case of *In re Betty Jean*[21] stating that: "where the protection rather than punishment of the offender is the aim . . . such criminal concepts require qualification." Also Judge H. W. Lindeman of the Newark Family and Juvenile Court went further expressing the view that:

> First, when some lawyer calls up and wants his own psychiatrist to interview a child held at Youth House for any purpose whatever, I think it quite proper to advise that (1) we have our own psychiatrist and psychologist available if that should be necessary prior to the hearing, and (2) the mental capacity of the child does not become a live issue until the decision is made as to whether the child did, in fact, commit the act complained of.[22]

Thus it would seem that in some cases the courts do not recognize the issue of incompetence to stand trial.

Generally, the issue of incompetency never reaches the stage of becoming a formal motion to the court. This is because of the

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19. Creek v. Stone, 379 F.2d 106 (D.C. Cir. 1967).

20. In the Survey, *supra* note 2, some 15 juvenile judges out of 34 indicated that incompetency to stand trial had been formally raised in their courts.

21. No. 27-220-J (D.C. Juvenile Ct. Oct. 20, 1959).

22. Memorandum of Judge H. W. Lindeman (Nov. 16, 1964). It is also the stated policy of New Jersey to disallow raising of the issues of mental competency or insanity before "guilt" or "innocence" has been established by the court.

The new Vermont Juvenile Code provides for the transfer of a juvenile to the probate court, which handles commitments, if the juvenile "court finds *after hearing* . . . there is evidence" of committability for mental illness (emphasis added).VT. STAT. ANN. tit. 33, § 657(b) (Supp. 1968).

flexibility of the pre-judicial stages of juvenile court proceedings. A former Michigan juvenile judge states that:

> I believe we have a different situation in our criminal courts than we do in our juvenile courts. Although it is recognized that our juvenile courts do need proof of fault, either in the form of delinquency or neglect, before it can enter an adjudicative order, our juvenile courts differ from the criminal courts in that the screening process as to whether or not a petition should be filed is carried on within the juvenile court rather than in the prosecutor's office . . . When it is apparent that the primary problem is connected with a mental disorder very often no petition will be authorized for filing, and the mental health resources of the community are swung into action (at least to the extent that they are available) independent of the official side of the juvenile court . . . I am sure that the police and prosecutors have much the same attitude about a number of their cases but they are not as well staffed to work out voluntary arrangements.[23]

In addition, simply because a delinquency complaint has been made, it does not mean that a formal delinquency petition will be filed. The juvenile court may choose instead to proceed under other jurisdictional provisions such as neglect, dependency or mental health.[24] When jurisdictional provisions other than delinquency are employed, legal arguments surrounding mental incompetency, are avoided and attention is focused directly on the juvenile's need for treatment.[25] If the juvenile court statute provides specifically for mental health jurisdiction, the court will usually have civil commitment or a similar commitment authority.[26]

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23. Survey, *supra* note 2.

24. A Mississippi juvenile judge states that: "there is no adjudication of delinquency *or* of an incompetent; neglect (is used) where necessary." Survey, *supra* note 2. See, *e.g.*, UTAH CODE ANN. § 55-10-77(2)(b) (Supp. 1967) which provides for jurisdiction over any child "whose behavior or condition is such as to endanger his own welfare or the welfare of others;" D. C. CODE ANN. § 11-1551 (a)(1)(G)(1967) "whose parent . . . neglects or refuses to provide or avail himself of the special care made necessary by his mental condition . . ."

25. Thus, some juveniles who would possibly be found incompetent to stand trial (or not guilty by reason of insanity) are removed from the delinquency process before they have a chance to raise these issues. Perhaps some of these juveniles do not want treatment and also have good defenses to the delinquency charges which brought them before the juvenile court in the first instance. One must conclude that changing jurisdiction from delinquency is for the most part beneficial provided that adequate notice is given to all parties.

26. *See, e.g.*, LA. REV. STAT. § 13-1570(E) (1968); NEV. REV. STAT. § 62.040(c) (1963); N.D. CENT. CODE § 27-16-08(4) (1960); VA. CODE ANN. § 16.1-158(2) (1950); WIS. STAT. § 48.14(3) (1957). The Proposed Family Court Act, Childrens Bureau, provides for civil commitment jurisdiction in the juvenile court. Letter from William H. Sheridan, (May 28, 1968).

Under current juvenile court statutes, the great majority of the juvenile courts do not have civil commitment authority although many have utilized other means to effect direct commitments to mental institutions. They commit under the juvenile code provisions relating to disposition, refer to committing courts or just rely on their inherent powers. In a few states the juvenile courts can only civilly commit *after* jurisdiction under other provisions of the juvenile code has been found. *See, e.g.*, UTAH CODE ANN. § 55-10-77(7) (Supp. 1967), which provides exclusive jurisdiction: "[f]or the treatment or commitment

The emphasis in the incompetency situation in the juvenile court appears to be more on treatment as an end in itself rather than as a means to bringing a person to trial. A California judge takes this view stating that:

> Ordinarily we are much more liberal in getting treatment for and the handling of juvenile incompetents as compared to adult incompetents. The law allows much greater opportunities for treatment.[27]

Also, juvenile courts probably base their decisions on competency on a broader base of information than is provided for in adult criminal courts. An Ohio judge states that:

> In the case of a juvenile, dependence would be based largely on competent clinical information furnished by other community sources such as school clinics, child guidance centers, etc. In the case of adults study of the current mental condition would be required.[28]

If a juvenile is found incompetent to stand trial in the juvenile court, treatment will usually be ordered. How treatment is obtained varies from court to court. Since many juvenile courts have no power to commit directly to state mental facilities, they must refer juveniles to the appropriate agency or court for observation and commitment. In many cases the juvenile court judge and the probate judge are the same person so that these mental commitments can be easily arranged.[29] Some courts commit directly to state mental hospitals using either their power under mental health laws or commitment authority under their juvenile codes.[30] Some courts rely on their inherent powers for commitments to state hos-

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of mentally defective or mentally ill child *who comes within the court's jurisdiction under other provisions of this section.*" (emphasis added); IND. ANN. STAT. § 9-3215 (Supp. 1967) provides that: ". . . [i]*f the Court shall find that the child comes within the provisions of this act* (§§ 9-3201-3225), it may . . . (2) [c]ommit the child to any suitable public institution or agency, which shall include, but is not limited to, the state institutions for the feeble minded, epileptic, insane . . . . (emphasis added).

27. Survey, *supra* note 2.

28. Survey, *supra* note 2. MASS. GEN. LAWS ANN., ch. 123, § 100 (1958), is the only juvenile statute which specifically provides for competency examinations for juveniles. D. C. CODE ANN. § 24-301 (1967) provides for competency procedures for the juvenile court but there has been a difference of opinion as to whether it applies to juveniles in addition to adults. One judge, at least, has utilized this Section for the mental examination of juveniles in St. Elizabeth's Hospital. Survey, *supra* note 2. THE MODEL RULES FOR JUVENILE COURTS, Rule 41. NATIONAL COUNCIL ON CRIME AND DELINQUENCY (proposed final draft 1968), provides for competency examinations in the juvenile courts but does not comment thereon. THE UNIFORM JUVENILE COURT ACT (1968) takes the more traditional approach toward mental problems. The Hawaii Family Court Act, HAWAII REV. LAWS § 333-22 (1955), provides that: "No child under the age of twelve shall be adjudged to come within the provisions relating to delinquency without the written recommendation of a psychiatrist . . ." This provision would appear to be aimed at establishing a younger juvenile's capacity to commit a wrongful or delinquent act rather than determine the juvenile's competency to participate in the juvenile proceedings.

29. Survey, *supra* note 2.

30. *See supra* note 25, *See also* ORE. REV. STAT. § 419.511(2) (1967).

pitals.[31] The juvenile statutes provide little or no guidance in this kind of situation.

B. What Happens to the Charges in the Incompetency Situation

What happens to the pending charges once a juvenile is ordered to receive treatment because of his incompetency to stand trial is similar to what happens to the charges in the voluntary psychiatric adjustment situation at intake. As a matter of fact, voluntary adjustments and determinations of incompetency are both really based upon the court's reluctance, growing out of a sense of justice, to adjudicate juveniles whose problems are basically psychiatric in origin. If intake functioned perfectly there could conceivably be no need for competency motions since serious cases of mental disorders would never reach the stages of a formal petition to the court. Due to the practical problems of lack of adequate resources, no juvenile court intake department can screen out all the cases it would like to.

In some states the juvenile court is required either by the psychiatric facility or statute to dismiss the charges if he incompetent juvenile is civilly committed.[32] To date, however, the general practice does not appear to require the juvenile court to do so as a matter of law.

With a few exceptions if the juvenile is committed for incompetency under authority of the juvenile code and not the mental health laws providing for involuntary commitments, there will be no requirement for the juvenile court to drop any charges unless the institution requests it to do so. The court will certainly keep the charges open if outpatient care or private residential care is ordered and will usually hold the charges in abeyance when civil commitments to state hospitals are made and premature release is a possibility or where the charges are particularly serious.

It is the better practice to have the charges dismissed where commitments are made because not only do the charges hinder the therapy process in certain cases, but they may also create due process problems of delay and uncertainty.

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31. A Maryland juvenile judge states that: "If a child needs treatment to protect himself or [the] public, I commit for treatment until it is safe to release him, using inherent authority. It has never been challenged." Survey, *supra* note 2.

32. COLO. REV. STAT. ANN. § 22-3-7(3) (Supp. 1967) provides that: "[t]he court shall dismiss the original petition when a child is committed to a state hospital . . ." ME. REV. STAT. ANN. tit. 15, § 2611 (.4)(g)(1964) also provides for civil commitments as a dispositional alternative with dismissal of the action if the civil commitment is actually made. The Proposed Family Court Act, 3rd Draft, Children's Bureau, includes a provision for the prompt dismissal of the allegations; a civil commitment takes place. Letter from William H. Sheridan, (May 28, 1968).

III. THE DEFENSE OF INSANITY IN JUVENILE COURT

A. Status of the Defense of Insanity

For various reasons the defense of insanity has been raised only infrequently in juvenile courts in the United States.[33] Because juvenile courts were grounded in the *parens patriae* philosophy, criminal responsibility was considered to be irrelevant, and hence the insanity plea was thought of as unnecessary for the protection of the minor.[34] As a matter of fact, no juvenile court statute specifically mentions the insanity defense. This is because the mental condition of the juvenile is supposed to be just another factor to be considered on disposition, provided the case is formally petitioned and adjudicated. A California juvenile judge maintains that:

> Due to [the] non-criminal nature of the Juvenile Court delinquency proceedings, the (insanity) would merely be another factor to be considered in determining the treatment needed for the child.[35]

Voluntary psychiatric adjustments at intake, substitutions for delinquency jurisdiction such as neglect, dependency and mental health jurisdiction, some incompetency determinations and resistance by juvenile judges and juvenile court personnel have cut down on the frequency with which insanity pleas have been raised in the juvenile court.[36]

Another important reason why the insanity defense is not used more often in juvenile court is the juvenile court's authority to transfer jurisdiction to the adult courts in the cases of older juveniles who commit serious felonies. An Ohio juvenile judge states:

> The court would allow the insanity defense if it had not seen fit to bind the individual over to the grand jury for the return of an indictment and trial under statutes governing adults.[37]

The Court of Appeals for the District of Columbia has ruled

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33. It has been raised in 5 of the 34 courts represented in the Survey, *supra* note 2. This writer knows of at least five other specific cases where the defense was raised.

34. Before the juvenile courts were established, juveniles apparently had the benefit of the insanity defense. *See* McClure v. Commonwealth, 81 Ky. R. 448, 452 (1883), where the court stated that a 13 year old boy, "was entitled to an instruction on insanity as well as on the presumption of law in his favor, based on his age." The latter presumes that children between 7 and 14 are incapable of forming the requisite criminal intent. It is a rebuttable presumption. The rule established in common law fell into disuse with the advent of the juvenile courts since the rule was supposed to mitigate the harshness of the criminal sanctions.

35. Survey, *supra* note 2.

36. A former Michigan juvenile judge states that he:
> " . . . would allow it (the insanity plea) if it went to trial, but the chances of it coming to trial would be slim unless it was a very questionable case."

Survey, *supra* note 2.

37. Survey, *supra* note 2.

against the waiver of mentally ill juveniles when civil commitment by or through the juvenile court is possible.[38]

In most cases it is probably to the juvenile's advantage not to raise the insanity defense even when he could since commitments to juvenile institutions usually are of short duration for practical reasons, the most important of which is serious overcrowding. A successful insanity plea might trigger an automatic confinement since juvenile judges would more than likely apply the adult insanity statute to the juvenile proceeding where the insanity plea is raised.

Juvenile judges do not appear to be as resistant to the insanity defense as is commonly imagined.[39] A Texas juvenile judge states that:

> The court has always allowed the defense of insanity, however, it now becomes obligatory on the court since the In re Gault decision states the law. The validity of the defense would have to be established in the same way as in a criminal case.[40]

While this appears to be too broad an interpretation of *Gault*, there is probably a far greater receptivity to defenses, such as insanity, since the *Gault* decision. It seems unlikely, however, that even with this change in attitude and increase of lawyer representation in juvenile courts that the insanity defense will be raised with much greater frequency than it has been. Most cases involving serious mental disorders will continue to be diverted before they reach the trial stages.

B. What Does the Juvenile Court Do When the Insanity Defense Is Raised Successfully

Juvenile court statutes give no guidance to juvenile judges on what they must do if a juvenile raises the insanity defense successfully. There is no question, however, that most juvenile courts would try to retain jurisdiction by some means and attempt to obtain psychiatric treatment for the juvenile. A Louisiana juvenile judge states that:

> Insanity is a valid defense to delinquency and should be allowed. The court, however, has a duty to the child to furnish through proper proceedings the care and treatment his condition might indicate.[41]

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38. Kent v. United States, 41 F.2d 408 (D.C. Cir. 1968).
39. All but a few of the juvenile judges in the Survey, *supra* note 2, indicated that they would allow the insanity defense were it ever raised.
40. Survey, *supra* note 2, Heyford v. Parker, 396 F.2d 393 (10th Cir. 1968) held that *Gault* required that a juvenile be represented by counsel in civil commitment proceedings.
41. Survey, *supra* note 2.

Typically, the juvenile court would probably file a new petition since the successful defense should theoretically defeat the juvenile court's jurisdiction under the delinquency petition. A Texas juvenile judge states that with respect to the successful insanity defense:

> If established as to that petition, a separate one relating to a child "whose behavior, condition, or circumstances are such as to endanger his own welfare or the welfare of others" would in most cases be filed.[42]

Thus the court will order treatment for the juvenile once he is brought within the jurisdiction of the court under neglect, dependency or like provisions.[43]

Some judges believe that they would not have any jurisdiction over the juvenile in the wake of a successful insanity defense. The reason for this belief is probably based on the judge's lack of statutory authority and his unwillingness to apply adult insanity statutes providing for further detention upon acquittal by reason of insanity. The following situation arose in the Boston juvenile court a few years ago:

> A child was brought into court for assault with intent to kill his grandmother. The court psychiatrist signed papers to commit the child to the Metropolitan State Hospital which declared him to be psychotic. He was then placed in the Boston State Hospital where he progressed. He even went home on weekends after a while which caused the court some worry over whether he might commit further violent acts.
>
> The court has not and will not move for trial because an insanity defense would obviously prevail and he would have to go free in the judge's opinion of the law. The lawyer refuses to move for trial because the child is receiving treatment which he could not obtain under any other circumstances. Since the child no longer appears to be acutely psychotic a commitment to a state hospital would be out of the question.[44]

In the absence of juvenile court statutory provisions for insanity procedures, some judges have indicated that they would apply or draw from appropriate provisions found in the criminal code dealing with insanity. The Supreme Court of Wisconsin upheld such a procedure in the case of *In re Winburn*, which allowed the plea of insanity in the juvenile court as a defense to a charge of delinquency.[45]

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42. Survey, *supra* note 2.
43. These would include referrals for civil commitments.
44. Confidential Source.
45. 32 Wis. 2d 152, 145 N.W.2d 178 (1966).

In this first degree murder case, the juvenile was found by the trial court to be mentally ill both at the time of trial and at the moment of the *actus reus*. He was civilly committed by the juvenile court on the condition that he not be released without a court hearing.[46] Finding that the child *was* "mentally ill and not responsible for his action" at the time of the shooting, the juvenile judge dismissed the delinquency petition on its merits. The state did not quarrel with the civil commitment of the juvenile because of his present insanity, but it did argue that the delinquency petition should not have been dismissed since the *actus reus*, alone, is sufficient to establish delinquency. A lack of *mens rea* is insufficient to void the whole petition.

In upholding the trial court's action, the Supreme Court of Wisconsin stated:

> The judge in his opinion pointed out that the act which was the basis for the petition was the commission of an offense described in the criminal statutes. He applied by analogy section 957.11(1) of the criminal statutes that provides that if a person charged with a crime is found insane or reasonable doubt as to his sanity exists at the time of the offense, he shall be found not quilty by reason of insanity.[47]

The court continued:

> The juvenile petition was based upon the violation of sec. 940.01, Stats. — first degree murder — that requires "intent to kill." A petition based on a violation that requires criminal intent cannot result in a finding of delinquency when the conduct was either unintended or when, because of insanity, there was a failure to form the requisite intent. Under the statute the juvenile judge had a clear right and duty to dismiss on the merits when the fact of insanity was proved by competent psychiatric testimony and that proof went unchallenged.[48]

While the insanity defense and civil commitment have traditionally been employed to cover two different classes of persons, the use of civil commitment proceedings in the criminal context is increasing. The criminal law again is following the juvenile court practice in this area. In *Bolten v. Harris*[49] it was held that automatic commitments of adult defendants acquitted by reason of insanity

46. *Id.* In many states it may not be possible for the juvenile court to retain jurisdiction over the juvenile once he is civilly committed. This situation would be especially true if another court must do the committing. The Wisconsin juvenile court, however, committed Winburn under a civil commitment power incorporated into the juvenile code.
47. In re Winburn, *supra* note 44, at 180.
48. *Id.* at 184.
49. 395 F.2d 642 (D.C. Cir. 1968).

were unconstitutional. The use of civil commitments was recommended if further confinement was believed to be necessary by the government. The equalization of rights and procedures between the civilly and criminally committed mental patients is also seen in the instances where the right to adequate mental treatment has been extended to the criminal incompetent and insane.[50]

Civil commitment coupled with dismissal of the delinquency petition can accomplish what the insanity defense does in adult courts and even more in that the juvenile is both relieved of criminal responsibility and receives the needed treatment. Problems surrounding arbitrary automatic commitments upon acquittal and the inordinate amounts of time and effort expended at trial when the insanity defense is raised can thus be efficiently avoided.[51]

In sum, then, the insanity defense has never caught hold in juvenile jurisprudence. It seems unlikely that it will ever become widely employed although it is being raised with somewhat greater frequency. Whether the insanity defense is truly a requirement of juvenile due process is the subject of debate; however, there appear to be suitable alternatives for the effective handling of juveniles with serious mental disorders who might be capable of raising the defense.

IV. DIAGNOSIS AND EVALUATION OF MENTALLY DISORDERED JUVENILES BY THE JUVENILE COURT

A. Outpatient Examination

Almost all juvenile courts are given express authority to order a juvenile coming before the juvenile court to be examined by a psychiatrist, psychologist and/or physician. Juvenile judges have great discretion in deciding who will be examined and, therefore, only those juveniles with suspected mental problems are referred to court or other clinics. Not only are existing court clinics under-

50 Rouse v. Cameron, 373 F.2d 451 (D.C. Cir., 1967); Nason v. Superintendent of Bridgewater State Hosp., Mass., 233 N.E.2d 908 (1968)

51. Another alternative to the insanity defense in the juvenile court is provided in proposed legislation in Massachusetts, Senate Bill No. 1355, § 14A (1967). Youthful offenders who commit serious offenses against the person shall be given a mental examination to determine whether the juvenile is "emotionally disturbed". Then:

> Upon a finding based on said study that the child is emotionally disturbed, the court shall hold a hearing and if it is found that the child has committed the offense charged and is in need of commitment the court shall place the child under the control and supervision of the Division of Youth Development and shall order him placed . . .

in a mental facility within the Division. The proposed act further provides the critical authority to:

> vacate its adjudication that an emotionally disturbed or mentally retarded child is a juvenile offender by reason of having violated any city ordinance, etc.

This alternative appears to be a very fair way of proceeding but clearly problems would arise in determining when the charges should be vacated. Namely, the old tests of criminal nonresponsibility would probably creep in although in a much less formal way.

staffed, but many juvenile courts have not been provided with any clinical facilities at all. As a consequence, it is undeniable that more juveniles should be given psychiatric and/or psychological examinations than are now receiving them.

Only rarely have juvenile courts allowed independent psychiatric examinations with public funds. Therefore, it is usually impossible for juveniles to obtain independent reports in addition to court ordered examinations and reports. Because court-related diagnostic clinics tend to conform their conclusions about a juvenile's mental condition to the resources available to the juvenile court, which are scarce, court-ordered examinations tend toward negative findings. The juvenile judges, in turn, generally place a very great reliance on these reports in determining whether a juvenile needs psychiatric intervention of some degree.

Even though treatment resources are scarce and are likely to remain so, it would seem wiser to have as complete a social file as is possible. Simply because treatment possibilities are not adequate, it should not mean that a juvenile's mental condition should not be fully explored. If the incidence of mental disorders were more accurately recorded, perhaps greater pressure could be exerted on the public and its governing bodies to produce adequate psychiatric resources.

Referrals for mental examinations are usually made by either the probation officer assigned to do the social study before disposition or the juvenile judge. In a small number of cases the respondent or family may request them. With the increase of lawyers in the juvenile court, it is likely that more examinations will be requested by the juveniles themselves because lawyers are accustomed to asking for them for a variety of reasons in adult criminal courts, not the least of which is delay.[52]

Under special circumstances many juvenile court statutes make mental examinations mandatory. For instance, Hawaii's Family Court Act requires all children under the age of twelve to be examby a psychiatrist before they can be adjudicated.[53] In many states juveniles being considered for waiver or certification to the adult criminal court for prosectution as adults must be given mental examinations. Even when not mandatory they are generally given in such situations. Ohio requires juveniles in the waiver situation to undergo testing at the Ohio youth commission diagnostic facilities or examination by some other qualified person or agency.[54] The

52. The MAKOVER REPORT, *supra* note 18, at 26, states that Law Guardians request psychiatric reports whenever there is a move to dispose of the case by placement of the child in a State Training School.

53. HAWAII REV. LAWS § 333-22 (1955).

54. OHIO REV. CODE ANN. § 2151.26 (Baldwin Supp. 1967).

District of Columbia Juvenile Court in the wake of *Kent v. United States*[55] formulated procedures for automatic Child Guidance Clinic evaluations where none has been given within the previous six months.[56] In several states mental examinations are necessary before commitments to state youth authorities or facilities may be ordered.

Usually the only qualification on the court's power to order mental examinations, if there is any at all, concerns *when* such examinations may be ordered. Even when there are such restrictions written into the statutes, they are not closely adhered to by the juvenile courts in actual practice. Some states simply require that a petition has been filed.[57] Some juvenile court acts, on the other hand, require a finding of delinquency before the mental examination may be ordered.[58] Many state statutes remain silent as to when examinations are to be ordered.[59]

It is difficult to say what the best approach is for giving mental examinations. Most juvenile judges appear to interpret their powers in this area very broadly. Some people, however, worry about compelling mental examinations prior to adjudication when the respondent does not raise his mental condition as some sort of defense.[60] Intake and informal adjustments might be unduly restricted if mental examinations were limited essentially to post-adjudication stages. As long as mental examination reports are not introduced into the fact-finding procedure, broad powers to order mental examinations should be retained.

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55. 383 U.S. 541 (1966).

56. Waiver standards of the Juvenile Court, May 18, 1966.

57. *See, e.g.*, FLA. STAT. ANN. § 39.08 (1961); HAWAII REV. LAWS § 333.22 (1955); IND. ANN. STAT. § 9-3220 (1956); IOWA CODE ANN. § 232.13 (Supp. 1968); LA. REV. STAT. §13-1570 (E) (1968); MICH. COMP. LAWS. § 712A.12 (1968); Family Court Act § 251, N.Y. JUD. (McKinney 1963).

58. *See, e.g.*, OKLA. STAT. ANN. tit. 20, § 841(a) (1962), (repealed, eff. Jan. 13, 1969) (Supp. 1968) which provides that: "[t]he Court may cause any person adjudged to be within its jurisdiction to be examined by a physician, psychiatrist or psychologist." Similar provisions are found in: COLO. REV. STAT. ANN. § 22-3-12 (Supp. 1967); IDAHO CODE ANN. § 16-1814(4) (Supp. 1967); NEV. REV. STAT. § 62-240(1) (1963); ORE. REV. STAT. § 419.511(2) (1967); UTAH CODE ANN. § 55-10-100(10) (Supp. 1967). *Cf.* OHIO REV. CODE ANN., § 2151.33 (Baldwin 1953) which provides: "Any person coming within sections 2151.01 to 2151.54 . . . may be subjected to a physical and mental examination . . . *Contra*, D.C. CODE § 16-2312 (1967); MO. ANN. STAT. 211.161. The U.S. Court of Appeals for the District of Columbia interpreted "coming under the court's jurisdiction" to mean the earliest possible point in the juvenile court process so as to effect the purposes of treatment, including detention prior to trial. Creek v. Stone, 379 F.2d 106, 110 (D. C. Cir. 1967).

Creek v. Stone, 379 F.2d 106, 110 (D. C. Cir. 1967).

59. *See*, ARIZ. REV. STAT. ANN. § 8-229(1956) ("if advisable").

60. THE MODEL RULES FOR JUVENILE COURTS takes the position that examinations should occur only after adjudication unless (1) consent is obtained, (2) neglect and child abuse is involved, (3) mental competency is raised or (4) the insanity defense is interposed. RULE 41, NATIONAL COUNCIL ON CRIME AND DELINQUENCY (proposed final draft 1968). The MAKOVER REPORT, *supra* note 18, at 105, takes the position that early identification of mental problems at intake is both possible and necessary and that availability of testing resources to intake workers is of critical importance and will increase the number of cases informally adjusted.

B. Residential Observation

In certain states it is questionable whether juvenile judges can order residential mental observations *before* adjudication.[61] In most states there is no problem because hospital observations are provided for specifically.[62] In those states where a juvenile judge does not have power to commit for residential observation before adjudication, the court does have the opportunity to refer the seriously disordered juvenile to the agency or court which handles civil commitments. Observation is then ordered by that authority and, if the juvenile is eventually not committed civilly, the juvenile court may proceed with the case having full benefit of the mental examination report. This would be, admittedly, a cumbersome way of obtaining residential observations before adjudication, but in most cases the juvenile or his family consents to the mental examination and there are therefore fewer problems than might appear at first glance.

Few, if any,[63] juvenile courts are without power to order residential observations after adjudication has been made. The problem, quite to the contrary, has been that far too many juveniles have been committed for residential observation when outpatient facilities could have been used. In many cases juveniles have waited in detention centers for very long periods of time for bedspace in hospitals to become available. Once the juvenile reaches the hospital, he spends a grossly disproportionate amount of time there in relation to the amount of time actually spent by professional staff in running tests and carrying on interviews. The juvenile courts should conform their practices to the existing practicalities of very limited bedspace and should utilize outpatient facilities as much as is possible.[64]

V. MENTAL DISORDERS AND THE DECISION TO WAIVE JURISDICTION TO THE CRIMINAL COURT.

Juvenile courts waive a comparatively small number of juveniles to the adult criminal court each year. Waiver, however, is important to the study of the mentally disordered juvenile, for, as

61. Survey, *supra* note 2.

62. The Hawaii Family Court Act, for instance, provides that: "[f]or such examination, or treatment, the court may place the child or minor in a hospital or other suitable facility." HAWAII REV. LAWS § 333-22 (1955). *See also, e.g.*, CAL. WEL. & INST'S CODE § 705 (West Supp. 1968); MASS. GEN. LAWS, *ch.* 123, § 100 (1958); Family Court Act § 251, N. Y. JUD. (McKinney 1963).

63. Survey, *supra* note 2.

64. Model Rule 41, *supra* note 59, states in part that:

> Any examination of a child under this rule shall be made on an outpatient basis unless the court, on the basis of testimony presented at a hearing at which the child is represented by counsel, orders the child placed in a hospital or other suitable facility.

was found from a study in the District of Columbia, a large percentage of those waived to the District Court by the District of Columbia Juvenile Court over the past several years have had mental problems of varying degrees of severity.[65]

There are several reasons why a juvenile with a mental disorder may be waived to the adult criminal court:

(1) The juvenile court may feel that the juvenile is too dangerous and cannot be handled in juvenile facilities.

(2) The court may determine that the juvenile needs treatment for his mental condition beyond the time to which juvenile court jurisdiction extends—usually eighteen to twenty-one years of age.

(3) In some states the juvenile court may not have ready access to secure psychiatric facilities available to the adult criminal courts.

(4) The juvenile court may not have the power to commit under laws such as those relating to sex offenders. Where the juvenile court has access to the same or comparable psychiatric facilities as the adult court have, there is less likelihood that juveniles with *serious* mental problems will be waived. A certain number of juveniles with less severe mental problems, probably, will be waived regardless of the availability of psychiatric resources to the juvenile court. In such cases other factors such as security will outweigh the mental condition factor in the courts decision.

Some attempts have been made to establish a policy against the waiver of seriously disordered juveniles to the criminal courts. The most recent case was *Kent v. United States,* 401 F.2d 408 (D.C. Cir., 1968) wherein the United States Court of Appeals strictly prohibited the waiver of a "seriously ill juvenile." (This decision would appear to have ended litigation in this protracted case.)

The primary reasons for waiving Kent to the District Court were:

(1) He had a very deteriorated mental condition which needed long term treatment. It was maintained by the court that treatment would continue beyond the time to which juvenile court jurisdiction would extend, namely twenty-one years of age. There was concern that the commitment would thus be prematurely terminated with a concomitant threat to the safety of the community.

(2) The juvenile correctional facilities did not have adequate psychiatric resources to give Kent extensive care which he obviously needed.

(3) The juvenile court did not believe that it had power under

65. THE ROLE OF MENTAL DISORDERS IN THE DECISION TO WAIVE JURISDICTION TO THE ADULT CRIMINAL COURT IN THE DISTRICT OF COLUMBIA, JUDICIAL CONFERENCE COMM. ON LAWS PERTAINING TO MENTAL DISORDERS (1968).

the District of Columbia Code section 24-301[66] which would enable it to commit Kent directly to the secure criminally insane section of St. Elizabeth's Hospital.

(4) A referral to the Mental Health Commission for the initiation of civil commitment proceedings probably would have necessitated the dropping of the charges against Kent since that was apparently the procedure of the Mental Health Commission.

The Court of Appeals states that:

> . . . waiver is a judgment that an adult criminal prosecution should be instituted against the juvenile . . . Treatment of a sick juvenile is not a concern of an adult criminal proceeding . . . psychiatric care was withheld from this schizophrenic juvenile for eighteen months from the date of his arrest while he was undergoing the trauma inherent in the incidents of a criminal prosecution.[67]

This statement is not entirely correct for one of the primary reasons for waiving Kent was the prospect that he would be declared incompetent or insane and thus receive the psychiatric care he needed. In many other cases in the District, older aggressive juveniles are waived despite their mentally disordered condition because it is known that they might be sent to the Federal Youth Center at Lorton, Virginia, where there is considerably more psychiatric therapy available than there is in the juvenile correctional institutions. The main problem is that the juvenile court cannot be sure that a particular juvenile will eventually be sent to St. Elizabeth's or Lorton. The remedy is to upgrade the juvenile institutions' psychiatric treament programs.

As an alternative to the waiver of mentally ill juveniles, the Court of Appeals suggests that:

> The juvenile court can institute civil commitment proceedings against the youngster. If commitment ensues, he will be confined and treated until he is no longer dangerous due to mental illness. If not, the juvenile court will be free to follow its usual procedures.[68]

By "usual procedures," the court probably meant the process whereby the released juvenile is subjected to a "detainer" and brought before the juvenile court on his original charges. The merits of such a procedure are extremely dubious and involve serious problems of delay and due process, especially where the respondent

66. Under D.C. CODE ANN. § 24-301 (1967), the District Court and General Sessions Court may commit incompetents and insane to certain hospitals.
67. Kent v. United States, *supra* note 37, at 411, 412.
68. *Id.* at 412.

and his family cooperate in the civil commitment and it is not made crystal clear what the juvenile court is intending to do with the charges at the time of the civil commitment. It seems fairer and far more efficient administratively to lodge civil commitment power in the juvenile court. Thus, a seriously disordered juvenile may be civilly committed, the charges may be dropped automatically, and the court may require a court hearing before release will be ordered.

Similar attempts have been made to protect against the waiver of seriously disordered juveniles although no clear cut policy has emerged with respect to the less seriously disordered juvenile who is not committable. The latter group are dealt with on a strictly case by case approach—a weighing of all the various social factors involved. Tennessee, for instance, had provided that before waiver there must be a finding that the juvenile is not insane.[69] The Hawaii Family Court Act allows waiver only after the court:

> finds that there is no evidence that the child is committable to an institution for the mentally defective or retarded or the mentally ill, is not treatable in any available institution or facility within the state designed for the care and treatment of children, or that the safety of the community requires that the child or minor continue under restraint for a period extending beyond his minority.[70]

It is doubtful that the juvenile with a mental disorder who is nonetheless not committable receives enough protection under statutes like the above. Many more juveniles could be retained under juvenile court jurisdiction were it not for the lack of adequate and secure facilities in the juvenile court correctional systems.

Usually waiver is based on a negative finding that the juvenile is no longer amenable to juvenile court rehabilitative efforts. Recognizing the shortsighted usefulness of this approach, it was argued in *Kent* that:

> the statute can be satisfied only by the comparative evaluation of the facilities available to the juvenile court and to the criminal court. . . . The question must be whether the juvenile court facilities are less adequate than are the facilities available to the criminal courts.[71]

While sound theoretically, such a procedure would be very impractical and speculative since the juvenile court has no way of

69. TENN. CODE ANN. § 37-264 (Supp. 1968). That part of the statute regarding insanity was repealed in 1968 by (Adj. S.), ch. 562, § 4.

70. HAWAII REV. LAWS 333.13 (1955). The UNIFORM JUVENILE COURT ACT, § 34(a)(4)(C) (1968), provides for this same finding of noncommittability.

71. Brief For Appellant, at 45-46, Kent v. United States, 401 F.2d 408 (D.C. Cir. 1968).

assuring that even if better adult facilities are available, the waived juvenile will receive the benefit of them.

In a very few cases, juveniles have raised the issue of their competency to be waived or to participate in the waiver proceedings. In denying a determination of such issues the juvenile courts rely on the argument that wiaver is basically a social determination and not a determination of guilt. However, where waiver includes a finding of probable cause that the wrongful act was committed, perhaps this concept has a certain amount of validity.

VI. THE DISPOSITION OF MENTALLY DISORDERED JUVENILES

A large number of juveniles suffering from mental disorders go through the adjudicative process and reach disposition. Inefficient intake, uncooperative parents, serious charges, lack of adequate psychiatric facilities and the inability or incapacity to raise either incompetency or insanity defenses can make pre-dispositional resolution of cases involving psychiatric problems impossible.[72]

While dispositional alternatives available to the juvenile judge are generally very meagre, the paucity of psychiatric resources heads the list.[73] Residential care is the greatest need of all although outpatient needs are very great.

A. Psychiatric Care as a Condition of Probation

All juvenile courts employ psychiatric conditions of probation although no juvenile code specifically provides for them. When a juvenile is a good probation risk, the court will order the juvenile with mental problems to attend an outpatient clinic as a condition of his probation. A tremendous amount of cooperation is necessary to make such conditions successful. However, juvenile courts are loath to enforce psychiatric conditions of probation for several reasons:

(1) The court, in certain instances, simply realizes that outpatient care is unavailable for the particular child.

(2) The court may not have the necessary staff to follow-up on such matters.

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72. The MAKOVER REPORT, *supra* note 18, at 24, states that:
> It is not at all unlikely that were psychiatric services available freely to the intake workers that the number of cases kept out of Court would be increased from about thirty-five per cent to perhaps sixty per cent. It is also possible that the more immediate availability of psychiatric services might result in more prompt placement in or in securing short term treatment in the community . . . .

73. THE ANNUAL REPORT OF THE BALTIMORE JUVENILE COURT (1966), by way of example, states:
> Facilities for treatment on an out-patient basis are practically nonexistent.... Specialized foster homes and available bed space in residential treatment centers can accommodate only a fraction of the children for whom such placement has been recommended.

(3) The court may not wish to enforce broken conditions as long as the juvenile appears to be staying out of trouble and doing fairly well without psychiatric care.

(4) Many courts simply do not have specific jurisdiction over the parents who are not willing to cooperate with such conditions.

Juvenile judges are divided over whether coercive action should ever be taken to enforce psychiatric conditions of probation. A Wisconsin juvenile judge states that:

> There is little one may do to get cooperation from an unmotivated parent. I can order them to appear at our clinic, but this just wastes the clinic's time.[74]

Other juvenile judges take the position that unless the reluctant juvenile gets to the clinic, the clinic will never have a chance to motivate the juvenile and obtain his trust in what they are trying to do for him. An Ohio juvenile judge takes a forceful approach, stating that: "the probation officer will take the child to the clinic and if necessary the child will be placed in detention until his appointment."[75] The problem is a difficult one and admits of no easy solution.

Various means are available to juvenile courts to enforce psychiatric conditions of probation. In some states juvenile courts have direct power over parents, and can order them to provide their child with outpatient care.[76] Some juvenile courts have brought contempt or neglect proceedings against uncooperative parents. Most juvenile courts rely solely on verbal coercion to obtain parental cooperation. One judge states that, "parents are brought before the court, matters are explained and their responsibilities are outlined to them."[77] Another states that he encourages the parents to cooperate by telling them he "expects the fullest cooperation from

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74. Survey, *supra* note 2. A Utah juvenile judge states that there is ". . . usually an order to show cause. Then if the child is too resistant, the requirement will be cancelled. . . . Results of enforced counselling have proven bad." Survey, *supra* note 2.

75. Survey, *supra* note 2. Commitment may have to be utilized. A juvenile referee in Maryland states that:

> If parents do not cooperate and do not accept help on an out-patient basis and a doctor says it is necessary, then the parents will be prosecuted for neglect. A Department of Public Welfare commitment will be made and a second effort to obtain out-patient care will be tried. If unsuccessful, the child will then be committed to an institution. If willful, the parent could be brought in for contributing to the delinquency of a minor and the child would be committed to the Department of Public Welfare. The use of contributing to the delinquency is rare. Confidential Source.

76. HAWAII REV. LAWS § 333.24(g). *Cf.* DEL. CODE ANN. tit. 10, § 985(c)(Supp. 1966) which provides:

> (c) The Court may, after reasonable opportunity to be heard, order the examined person, or the person legally liable for his support, to repay the Court for its outlay on his behalf, such sum, in such manner, within his ability, as the Court determines.

Several other states have identical provisions but it appears that they are not used extensively to provide psychiatric care but are used more for emergency medical treatment.

77. Survey, *supra* note 2.

them. The parents believe the court has the power to order them to cooperate."[78]

On the whole, it would probably be better if greater persuasion, coupled with coercion where appropriate, were used, especially in the initial stages of the treatment process due to the many social, cultural and practical obstacles placed in its way. Greater follow-up by court personnel will greatly facilitate progress in this area.

B. Jurisdiction of Juvenile Courts to Continue Cases Without Making a Finding on the Facts

In many jurisdictions, cases may be continued without a finding being made—even after there has been a hearing on the merits of the delinquency complaint.[79] In the case of a juvenile who has contested the delinquency charges, this may be his only chance of working out an informal adjustment since many juvenile courts lose jurisdiction once the judgment is entered and the juvenile is committed to a training school or youth authority.

C. Commitment of Mentally Disordered Juveniles at Disposition[80]

Even when the juvenile court has authority to commit directly to state mental institutions, there is no assurance that the hospital will accept its referrals. A former Michigan juvenile judge states that:

> A number of our state hospitals have special units for children who are mentally ill. These are generally cooperative with the courts to the extent that they have space. But the waiting period now is well over a year, so that in only exceptional cases are they of much help to the juvenile courts in terms of residential care.[81]

In many cases juveniles who would otherwise be diagnosed as

78. Survey, *supra* note 2.

79. *See, e.g.*, CONN. GEN. STAT. ANN. § 17-68 (1958); IND. ANN. STAT. § 9-3215(4) (Supp. 1968); IOWA CODE ANN. § 232.34(1) (Supp. 1968); MINN. STAT. ANN. § 260.185 (Subd. 3) (Supp. 1967). Newer statutes like ILL. ANN. STAT. ch. 37, § 704-8(1) (Supp. 1967) provide:

> . . . If it [court] finds that the minor is not such a person [delinquent] or that the best interests of the minor and the public will not be served by adjudging him a ward of the court, the court shall order the petition dismissed . . .

80. Many juveniles with mental problems go through the regular judicial process not only because of the inability to reach pre-judicial adjustments but because certain states require adjudication before psychiatric treatment can be ordered. *See, e.g.*, FLA. STAT. ANN. § 39.08 (1961) which provides that:

> [a]fter a child has been adjudicated . . . the judge may order the child to be treated . . . [and] . . . the judge may order the child to be placed in a suitable place.

IDAHO CODE ANN. § 16-1814(4) (Supp. 1967); UTAH CODE ANN., § 55-10-100(10), (14) (Supp. 1967); IOWA CODE ANN. § 232.13 (Supp. 1968).

81. Survey, *supra* note 2.

psychotic are given nonpsychotic labels or simply referred back to the juvenile court for lack of space. Only the acutely psychotic are usually accepted by them.

Placement in private residential psychiatric facilities is always desirable for juveniles who need to be confined.[82] Private residential facilities willing to accept the seriously disordered juvenile delinquent are relatively few in number. They are practically nonexistent for the older, aggressive delinquent.[83] Where private facilities exist the waiting lists are long, special qualifications for entrance exist, and tuitions are usually very high.[84]

In certain jurisdictions it is necessary to make the juvenile a ward of the court or other public agency in order to get the benefit of public funds for private residential placements. Private residential facilities generally look with favor upon court or public agency involvement. It protects the institution and child from capricious and meddlesome parents; provides an additional source of backup revenue should primary sources fail; and, makes available certain after-care services upon release from the institution.

When a juvenile delinquent with a mental disorder cannot be placed in a state or private mental facility and is a poor probation risk, the regular juvenile training or correctional institution will be utilized. As the Makover Report states: "training schools with insufficient or no facilities for psychiatric treatment were, therefore, the only resources that were practically available in most cases needing placement."[85] These institutions are ususally only used as a last resort because of their extreme lack of psychiatric resources. Most of the time, juvenile judges have very little choice but to send a mentally disordered juvenile to the training school. The results of these commitments are obvious.

Recent modifications of the Children's Bureau Standards for Juvenile and Family Courts have recognized this problem stating that:

> No commitment as a delinquent or child in need of supervision may be made if the child is found to be committable as mentally retarded or mentally ill. In such case, commit-

82. The use of foster group homes for emotionally disturbed children is developing as an alternative to hospitals and correctional institutions.

83. The MAKOVER REPORT, *supra* note 18, at 25-26, found that juvenile judges were reluctant to refer juveniles for psychological testing by the court clinic when private placements were planned because they were futile in light of the scarcity of resources available.

84. While the great majority of juvenile courts have the power to make commitments to private psychiatric institutions, many of the juvenile judges in the Survey, *supra* note 2, indicated that they have never made such commitments.

85. MAKOVER REPORT, *supra* note 18, at 110.

> ment shall be made to the appropriate agency for instituting the proper proceeding for such commitment.[86]

The problem of inadequate psychiatric treatment would still remain for those juveniles, not committable, but who nevertheless need extensive psychiatric treatment. Some states have already established statutory safeguards against committing seriously disordered juveniles to regular correctional institutions.[87] These statutes do not solve the problem, however, as a former Michigan juvenile judge has stated, "we find that some of our state hospitals will not accept mentally ill children if they are also delinquent" and,

> our juvenile courts cannot commit to our state department of social services for admission to our training schools for delinquents unless the youngster is sound in mind and body.[88]

This impasse created by public health and correctional authorities, reluctant to care for the seriously disordered juvenile, is common throughout the country.

Authorities in health and corrections may try to work out guidelines on their specific responsibilities. An official in the California Youth Authority states that:

> Over the years the state's correctional schools and the State Department of Mental Hygiene have each attempted to avoid the assumption of responsibility for youngsters who are both delinquent and disturbed. In a general sort of way it was decided that unless the youth warranted an outright psychiatric diagnosis and if he was committable to the Youth Authority that this agency (Youth Authority) should handle the problem. We continue to have the resources of the Department of Mental Hygiene hospitals whenever youths are diagnosed by our clinical staff as fitting the more obvious psychiatric diagnosis.[89]

Clearly then, greater efforts must be made at defining the responsibility of health and correctional authorities. If the juvenile courts take a greater role in the review of their own commitments, perhaps greater protection can be assured to the mentally disordered juvenile.

VII. THE JUVENILE COURT'S ROLE AFTER DISPOSITION OF THE MENTALLY DISORDERED JUVENILE

If a juvenile on probation or in a private institution following

86. Modifications of Positions taken by the Children's Bureau in Standards for Juvenile and Family Courts, March 29, 1968.
87. *See*, CAL. WEL. & INST'S CODE §734 (West 1966).
88. Survey, *supra* note 2.
89. Confidential Source.

disposition becomes in need of psychiatric residential care, the juvenile court usually must order it. Whereas, if the juvenile has been committed to a youth authority or training school,[90] the transfer to a mental hospital is generally arranged without the active participation of the juvenile court.[91] Some juvenile courts retain jurisdiction over their commitments to training schools and the like institutions and therefore must authorize any transfers of the juvenile.

Juvenile courts generally take a very permissive view of what happens to a juvenile once he has been committed to a hospital or correctional authority. Greater initiative on the part of juvenile courts must be taken to see that the special psychiatric care which is recommended for a particular juvenile is being received.[92] Until recently, the juvenile courts have not become involved in the review process because (1) they believe correctional or health authorities have more expertise than they, (2) the juvenile court's jurisdiction does not extend so far,[93] or (3) there is no real alternative available which would provide the juvenile with better care than he is already receiving.

If juvenile judges made a greater effort at enforcing their order, more attention would be focused on this critical problem. There is no question that health and correctional authorities would resist such efforts. Perhaps communities would spend more money on better facilities if the juvenile courts were forced to release some juveniles because of the woefully inadequate psychiatric treatment they are receiving at juvenile institutions.

With the increase of lawyer representation in the juvenile courts, perhaps more reviews of commitments will take place. The effectiveness of challenging the inadequacy of treatment is demonstrated by the experience of a Utah juvenile judge who states that:

> We have had five such cases in which inadequate treatment was alleged but the issues never came to a hearing because of technical pleading grounds. The institutions backed away and released.

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90. Juvenile court jurisdiction usually ceases. *See, e.g.*, FLA. STAT. ANN. § 39.11 (4) (Supp. 1968); IOWA CODE ANN. § 232.35 (Supp. 1968); TEX. REV. CIV. STAT. ANN., art. 2338-1-5(c) (Vernon Supp. 1968).

91. MO. ANN. STAT. § 211.201(2) (Supp. 1968).

92. In re Elmore, 382 F.2d 125 (D.C. Cir., 1967).

93. LA. STAT. REV. ANN. § 13.1572 (1968) provides:

> It is, however, declared to be the public policy of this state that whenever the custody of a child is assigned to a public or private agency or institution by the court such instrumentality shall be encouraged and permitted to exercise its discretion in the treatment, training, supervision, and discipline of the child in order that the child may derive the maximum benefit from experience and qualified professional services; *it being the intention that the court shall not be burdened or directly concerned with the techniques, plans and details of such services but shall concern itself primarily with the overall consideration being given to the welfare of the child.* (emphasis added).

CONCLUSION

There is no question about the need for greater uniformity and regularity in the handling of the mentally disordered juvenile. While adequate psychiatric care will never be achieved without the addition of far more psychiatric facilities to those already available to juvenile court, improving present procedures can help a great deal in removing barriers to treatment which exist apart from the scarcity of resources. Greater consideration must be given to the specific problem areas discussed above by legislators, judges and court administrators in order that juveniles, their parents and legal representatives will know what to expect from the court if the child has mental problems and, thus, can act accordingly.